ACER ACRT UPDATE

WASHINGTON STATE DEPARTMENT OF LICENSING

Assessment/Treatment Report for DASA Certified Agencies

File this report with: Department of Licensing, PO Box 9030, Olympia, WA 98507 or Fax: 360-570-7044
Drivers with DOT positive tests dated after July 24, 2005 must be assessed by a Substance Abuse Professional.

Please print or type.

Client name *(Last, First, Middle)*		Washington driver license number
Residence address ☐ PLEASE CHECK IF NEW ADDRESS		Date of birth
City	State	ZIP code
Mailing address		
City	State	ZIP code
Agency name		Agency (Area code) Telephone number
Agency street address		Agency Greenbook number
City	State	ZIP code

Assessment

I completed an assessment of the above named person on _____.
Assessment date

My findings are:*

☐ **Insufficient evidence of substance abuse/dependence.** Individuals with a low probability of reoffending, that require Alcohol/Drug Information School for a problem with substance use and driving.

☐ **Substance abuse.** Individuals with a greater probability of reoffending, whose apparent primary problem is not substance dependence. An extensive education/prevention treatment program, is required; intensive treatment for substance dependency is not.

☐ **Substance dependence.** Individuals with a greater probability of reoffending, whose apparent primary problem is substance dependence. This category includes individuals in any stage of the recovery process, including those indicating recovery through non-treatment means).

**These are guidelines for determining the appropriate reporting level.*
It is the responsibility of the assessment professional to identify and document the symptoms that support their decision.

X _____ _____
Signature of chemical dependency professional / assessment officer — Date signed

Information School

☐ Client completed information school on _____.
Completion date

X _____ _____
Signature of certified information school instructor — Date signed

Treatment Reports--Submit within 5 days

Check all appropriate boxes:

☐ **Progress.** Treatment began on _____. Patient completed first 60 days with satisfactory progress.
Date program began

☐ **Noncompliance report.** Patient is noncompliant (includes any violation of the treatment plan that reflects the patient's unwillingness or failure to participate).

☐ **Compliance report.** Patient is again complying with treatment program.

☐ **Transfer report.** Patient transferred: ☐In ☐Out on _____.
Transfer date

☐ **Discharge report.** Patient completed treatment and aftercare program: ☐Yes, on _____.
Completion date
☐No, _____.
Explain

X _____ _____
Signature of chemical dependency professional — Date signed

The Department of Licensing has a policy of providing equal access to its services.
If you need special accommodation, please call (360) 902-3900 or TTY (360) 664-0116.